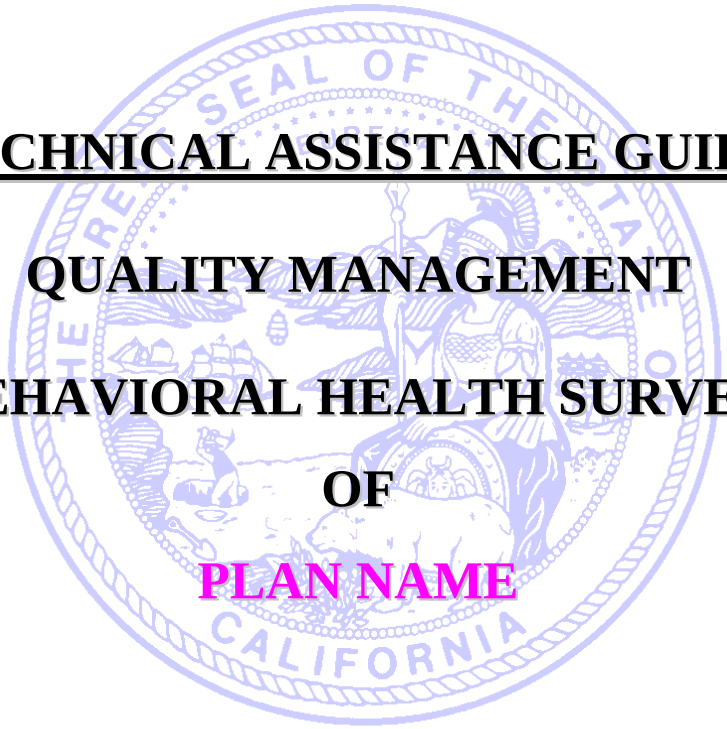
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS



TECHNICAL ASSISTANCE GUIDE

QUALITY MANAGEMENT

BEHAVIORAL HEALTH SURVEY

OF

PLAN NAME

PLAN COPY

Issuance of this October 1, 2008 Technical Assistance Guide renders all other versions obsolete.

Technical Assistance Guide (TAG)
Plan Name:
Surveyor Name:

BEHAVIORAL HEALTH TAG

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*The following Quality Management Requirement from the Full Service TAGs is not applicable to Behavioral Health Plan Surveys:

- Requirement QM-005: QM Delegation Oversight

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Requirement QM-001: QM Program Intent and Regulatory Purpose, Structure and Requirements

Statutory/Regulatory Citations:

28 CCR 1300.70 (a) (1-4)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.
(4) The Department's assessment of a plan's QA program will focus on:
(A) the scope of QA activities within the organization;
(B) the structure of the program itself and its relationship to the plan's administrative structure;
(C) the operation of the QA program; and
(D) the level of activity of the program and its effectiveness in identifying and correcting deficiencies in care.

28 CCR 1300.70 (b) (1)
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
(B) quality of care problems are identified and corrected for all provider entities;
(C) physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
(E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

28 CCR 1300.70 (b) (2) (A-F)
(b)(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.
(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

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(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.
(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.
(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- CEO
- Board Member (if feasible)
- QA Director
- QA Committee members
- Designated physician/clinician that provides oversight of QA Program
- Providers that participate in the QA Program

Documents to be Reviewed:

- QM Program description and/or plan
- QM Work Plan or action plan
- Organizational charts showing the relationship of the QM department and committees to the overall structure and the accountability of senior management for QM activities
- Annual QM plan evaluation for the last two years
- Minutes of the QM Committee or its equivalent and its subcommittee meetings for the last 18–24 months
- Meeting Minutes of Governing Body review of QM monitoring results.
- Job description and resume of physician or other clinician, as appropriate, who provides clinical direction to the QM program
- Review licensing filing of the Plan's QM program and confirm submission of appropriate policies and procedures.

Key Element 1:

1. The Plan has established and documented a QM Program consistent with regulatory purpose and intent. (Pre-Onsite Scoring) 28 CCR 1300.70 (a); 28 CCR 1300.70 (b) (1) and (2)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a written description of the QM Program?			
1.2 Is a physician or other licensed provider designated to provide clinical direction to the QM program?			
1.3 Does the designated physician hold a current unrestricted California license to practice medicine?			
1.4 Is there evidence that the designated physician is substantially involved in QM program operations evidenced by time commitment, clinical oversight and guidance to QM staff?			
1.5 Does the QA plan confirm a quality of care monitoring cycle: 1) problems are identified, 2) effective action is taken to improve care when deficiencies are identified, and 3) follow-up is planned where indicated?			
1.6 Does the scope of the QA Program address service elements, including accessibility, availability, and continuity of care?			
1.7 Does the scope of the QA Program monitor whether the provision and utilization of services meets professionally recognized standards of practice?			

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Key Element 2:

2. The QM Program is designed/structured to ensure effective quality oversight. (Pre-Onsite Scoring) 28 CCR 1300.70 (b) (1)

Assessment Questions	Yes	No	N/A
2.1 Does the QA program ensure that the level of care being delivered to all enrollees meets professionally recognized standards of practice?			
2.2 Does the Plan have mechanisms to identify and correct quality of care problems for all provider entities?			
2.3 Are physicians (or in the case of specialized plan, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to enrollees an integral part of the QA program?			
2.4 Does the Plan track and trend quality of care provided by *individual* providers/provider groups against professionally recognized standards of practice (e.g., provider-specific rates, investigation of complaints regarding specific cases, site visits)?			

Key Element 3:

3. The written QM Program meets defined requirements. (Pre-Onsite scoring) 28 CCR 1300.70 (b) (2) (A), (B) and (F)

Assessment Questions	Yes	No	N/A
3.1 Does the QM program describe the goals and objectives of the program and organization arrangements?			
3.2 Does the Plan include staffing, clinical and administrative staff support with sufficient knowledge and experience to assist in carrying out their assigned QM activities for the plan and delegated entities?			
3.3 Does the QM Program include the methodology for ongoing monitoring and evaluation of health services?			
3.4 Does the QM Program include the scope of the program and required levels of activity?			
3.5 Does the QM Program delineate the QA authority, function and responsibility?			
3.6 Did the Plan provide evidence that the QM Program has established quality assurance activities?			
3.7 Was the QM Program approved by the governing body?			

Key Element 4:

4. The Plan's Governing Body provides adequate oversight of the QM program (e.g., reviews detailed reports of findings and actions of the QM program at least quarterly, periodically reviews the QM program description, reviews and approves goals and objectives). 28 CCR 1300.70 (a) (1); 28 CCR 1300.70 (b) (2) (C)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan's Governing Body review regular QA monitoring reports at least quarterly?			
4.2 Are the reports to the Plan's Governing Body sufficiently detailed to include findings and actions taken as a result of the QM program?			
4.3 Are the reports to the Plan's Governing Body sufficiently detailed to identify any significant or chronic quality of care issues?			
4.4 Does the Governing Body act upon the reports and information provided (e.g., by providing feedback, instructions and recommendations to QM program staff)?			

End of Requirement QM-001: QM Program Intent and Regulatory Purpose, Structure and Requirements

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Requirement QM-002: QM Program Monitors the Full Scope of QM Activities (Pre-Onsite Review)

Statutory/Regulatory Citations:

CA Health and Safety Code section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.

This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

28 CCR 1300.70 (a) (1-3)

(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

28 CCR 1300.70 (b) (1) (A-D)

(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
(B) quality of care problems are identified and corrected for all provider entities;
(C) physicians (or in the case of specialized plans, dentists, optometrists, psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others;

28 CCR 1300.70 (b) (2) (C-E)

(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a

regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.
(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.
(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

California Business and Professions Code Section 805:
(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) "805 report" means the written report required under subdivision (b).
(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date of any of the following that occur as a result of an action of a peer review body:
(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.
(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

(c) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason:
(1) Resignation or leave of absence from membership, staff, or employment.
(2) The withdrawal or abandonment of a licentiate's application for staff privileges or membership.
(3) The request for renewal of those privileges or membership is withdrawn or abandoned.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

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Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director responsible to supervise the implementation of the QM program.
- QM Director or equivalent
- Member Services Director
- UM Director/ Medical Director involved in UM Review
- QM Committee members
- Participating providers
- Staff responsible for developing and analyzing reports
- Delegate Clinical Director, if plan delegates QM
- Delegate Director of Quality Improvement, if plan delegates QM

Documents to be Reviewed:

- QM Reporting and Analysis Plan;
  - Utilization reports
  - Mortality/morbidity rates
  - Reports/analysis of complaints and grievances
  - HEDIS results for the last three years, if applicable
  - QA activity reports, documentation and studies
  - QA Committee or applicable subcommittee minutes
  - Enrollee/provider satisfaction surveys results
  - Access and availability studies including telephone access studies
  - Special ad hoc reports to the Board, if applicable
  - Files detailing the review access/ availability complaints, continuity of care, utilization of services
- List of established performance goals and associated tracking reports
- QM Committee and Subcommittee meeting minutes
- Related policies and procedures, including: the process for investigating quality of care, system issues and/ or administrative problems, monitoring procedures including problem Identification, evaluation, corrective action and follow-up monitoring.
- Policy and procedure for peer review and Section 805 reporting
- Peer Review Committee Minutes
- Section 805 reports
- PQI Log
- Sample of PQI files to be reviewed on site.
- PQI track and trend reports by provider, by issue and by level of severity of confirmed problems

Key Element 1:

1. The Plan monitors required service elements and utilization of services and identifies and corrects quality of care problems for all provider entities. 28 CCR 1300.70 (a) (3)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan monitor accessibility, availability, and continuity of care?			
1.2 Does the Plan's monitoring and analysis include all provider entities? (e.g., physicians, hospitals, outpatient surgery centers)			
1.3 Does the Plan's monitoring and analysis include all service types (e.g., preventive care, primary care, specialty, emergency, inpatient, ancillary)			
1.4 Does the Plan's monitoring and analysis include mental health provider performance against one or more of the established mental health parity clinical practice guidelines?			
1.5 Does the Plan monitor whether the provision and utilization of services meets professionally recognized standards of practice?			
1.6 Are the Plan's data collection and reporting systems adequate to produce reliable and timely data and reports from various business units?			
1.7 Does the Plan continuously monitor and document all service elements and utilization services?			

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Assessment Questions	Yes	No	N/A
1.8 Does the Plan use appropriate study designs and sound statistical techniques when monitoring, conducting studies and developing reports?			

Key Element 2:

2. The QA Program must document that problems are being identified. 28 CCR 1300.70 (b) (1) (B,C); 28 CCR 1300.70 (b) (2) (C)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan utilize a variety of monitoring approaches (e.g., standardized performance measures; provider site visits; satisfaction surveys; investigating, tracking and trending enrollee complaints/grievances; investigating provider complaints) to identify problems in service and care?			
2.2 Does the Plan refer identified issues, if any, to the QM Committee or other appropriate body for input when appropriate?			
2.3 Does the Plan track issues referred for quality review (e.g., complaints referred from G&A Dept. to QM Dept.) to ensure that all issues are investigated and that investigations are timely?			
2.4 Where the Plan has failed to meet performance goals or targets, does it conduct gap analysis and investigate barriers to better isolate the problems for both clinical and non-clinical aspects of its health service delivery?			

Key Element 3:

3. When problems are confirmed or performance goals are not met, the Plan formulates and implements effective corrective actions in a timely manner. 28 CCR 1300.70 (a) (1); 28 CCR 1300.70 (b) (1) (B) and (D); 28 CCR 1300.70 (b) (2) (C)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan implement corrective actions or QM programs to address identified quality issues?			
3.2 Does the Plan incorporate input from appropriate professionals into the design of its corrective action plans or QM programs?			
3.3 Does the Plan assess the effectiveness of its corrective actions or QM programs?			
3.4 Does the Plan critically evaluate the outcome of its corrective actions or QM programs and take steps to rectify continued deficiencies?			

Key Element 4:

4. The QA Program must be directed by providers and must document that the quality of care provided is being reviewed. CA Health and Safety Code section 1370; 28 CCR 1300.70 (a) (1); 28 CCR 1300.70 (b) (2) (C-E)

Assessment Questions	Yes	No	N/A
For individual cases/providers (e.g., cases identified through complaints or sentinel events involving the quality of care provided by the provider): 4.1 Does the Plan have an established process for investigating quality of care cases?			
4.2 Does the Plan involve clinicians with the appropriate knowledge or specialty (e.g., MDs, Ph.Ds, MFCCs, LCSWs) in the review process?			
4.3 Does the Plan complete investigations involving quality of care issues within the timeframes established by the Quality Management and Peer Review programs?			
4.4 Does the Plan have a peer review mechanism in place?			
4.5 Does the Plan have a system to judge the severity of issues and the care involved that relies on professionally accepted standards of practice?			
4.6 Is the Peer Review case scoring system standardized, defined and communicated to all physicians involved in Peer Review?			

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Assessment Questions		Yes	No	N/A
4.7	Does the Plan refer cases to a Peer Review Committee or other appropriate body of clinicians when appropriate?			
4.8	Does the Plan have policies and procedures that establish a method for reporting determinations of the peer review body in accordance with Section 805?			
4.9	If the Plan has denied a licentiate's application for membership, terminated membership, imposed a summary suspension of membership or imposed restrictions, or if a licentiate has resigned following notice of an impending investigation, has the Plan filed an 805 report?			
4.10	Does the Plan either prescribe a corrective action plan or require that the offending provider submit a corrective action plan?			
4.11	Does the Plan follow through and request evidence that corrective actions have been implemented by the offending providers?			

End of Requirement QM-002: QM Program Monitors the Full Scope of QM Activities (Pre-Onsite Review)

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Requirement QM-003: Precautions to Ensure Appropriate Care is Not Withheld or Delayed for Any Reason

Statutory/Regulatory Citations:

28 CCR 1300.70 (b) (1) (D) and (E)
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and
(E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- QA Director
- QA Coordinator

Documents to be Reviewed:

- Organizational chart depicting reporting relationships between QM and other departments.
- Physician Reviewer agreements with the Health plan. Contract terms and conditions.
- List of QM Committee members and titles, role and responsibility within the Committee, if any.

Key Element 1:

1. The QM Program is designed to ensure appropriate care is not delayed or withheld for any reason. 28 CCR 1300.70 (b) (1) (D) and (E)

Assessment Questions	Yes	No	N/A
1.1 Can the Plan demonstrate there is no financial incentive or gain to the plan providers and/or others to delay or withhold appropriate care?			
1.2 Can the Plan demonstrate that it does not exert economic pressure on institutions to grant privileges to health care providers that would not otherwise be granted?			
1.3 Can the Plan demonstrate that it does not pressure health care providers or institutions to render care beyond the scope of their training or experience?			
1.4 Are all treatment decisions rendered by appropriate clinical staff, void of any influence or oversight by the Finance Department?			
1.5 Does the Medical Director's responsibility to supervise medical management of the Plan's benefits occur without financial influence by the Finance Department?.			

End of Requirement QM-003: Precautions to Ensure Appropriate Care is Not Withheld or Delayed for Any Reason

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Requirement QM-004: Credentialing (formerly QM-006)

Statutory/Regulatory Citations:

28 CCR 1300.51 (d) (H) (iii)
Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.

28 CCR 1300.67.2 (e)
A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.

28 CCR 1300.67.60 (e) (1-4)
(e) For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or

(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or

(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or

(4) Meets the following qualifications:
(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
(B) Has completed any of the following:
1. In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 ours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum or 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

CA Health and Safety Code section 1367 (b)
Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

Individual(s)/Position(s) to be Interviewed:

Staff interviews are not required or recommended unless a specific concern is identified.

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Documents to be Reviewed:

- Related policies and procedures, including: credentialing and re-credentialing; ensuring all Plan providers and all participating providers, both individual an institutional, are licensed and/or certified; ensuring participating primary care physicians and specialists have admitting staff privileges with at least one participating hospital; ensuring all participating medical specialists are certified or Board eligible; identifying providers whose licenses have been suspended or revoked; etc.
- Contracts with individual providers
- Contracts with contracted entities, including provider groups
- Complaint and grievance reports
- Delegation contracts as applicable
- Monitoring and tracking reports of credentialing and re-credentialing

Key Element 1:

1. The Plan verifies that all Plan provider staff and all participating providers, both individual and institutional, are licensed and/or certified, as required by law. CA Health and Safety Code section 1367 (b); 28 CCR 1300.67.60 (e)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures for verifying licensure/certification of its providers at the time of acceptance into the Plan network?			
1.2 Does the Plan have a mechanism to identify on a periodic basis providers whose license has been suspended or revoked?			
1.3 Does the Plan have criteria for identifying a provider as an HIV/AIDS specialist?	N/A	N/A	
1.4 Has the Plan established a corresponding mechanism for credentialing and re-credentialing HIV/AIDS providers in accordance with the regulation?	N/A	N/A	

Key Element 2:

2. The Plan verifies that participating primary care physicians and specialists have admitting staff privileges with at least one participating hospital. 28 CCR 1300.51 (d) (H) (iii)

Assessment Question	Yes	No	N/A
2.1 Does the Plan have established requirements for provider admitting staff privileges in participating hospitals?			

Key Element 3:

3. The Plan verifies that all participating medical specialists are certified or eligible for certification by the appropriate specialty board. 28 CCR 1300.67.2 (e)

Assessment Question	Yes	No	N/A
3.1 Does the Plan have established requirements regarding provider certification or board eligibility with the appropriate specialty board?			

End of Requirement QM-004: Credentialing (formerly QM-006)

BEHAVIORAL HEALTH TAG

Requirement QM-005: QM Delegation Oversight

This requirement does not apply to Behavioral Health plans.

End of Requirement QM-005: QM Delegation Oversight